June 19, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1162-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is a board certified anesthesiologist. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 30 year-old male who sustained a work related injury on ___. The patient reported that while at work a stack of handrails fell on his left calf, twisting his left knee and his left ankle. The patient underwent X-Rays at an emergency room four days later where it was determined he sustained a fracture of the left fibula. The patient underwent an MRI on 1/19/01 that shoed a meniscus tear and some bone bruising of the tibial plateau. Another MRI on 4/12/01 showed lateral tenosynovitis in the ankle. The patient underwent a partial medical and lateral meniscectomy in the knee and a thermal synovectomy on the left ankle. The diagnoses for this patient included tear medial and lateral menisci of the left knee and traumatic sysnovitis left ankle.

Requested Services

Left Lumbar Sympathetic Block.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 30 year-old male who sustained a work related injury to his back on ___. The ___ physician reviewer also noted that the patient sustained a fracture to the left fibula, left meniscus tear and bruising of the tibial plateau and lateral tenosynovitis in the left ankle. The ___ physician reviewer further noted that this patient has undergone a partial medial and lateral meniscectomy and thermal synovectomy of the left ankle. The ___ physician reviewer indicated that this patient continues to complain of pain over the left ankle, edema of the left foot and ankle as well as color and temperature changes of the left foot. The ___ physician reviewer explained that this patient has been treated with medical therapy and interventional therapy that included sympathetic blocks on 9/5/02 and 10/25/02. The ___ physician reviewer also explained that there is no documentation indicating that this patient obtained/sustained pain relief from the previous nerve blocks. The ___ physician reviewer indicated that the patient continued to rate his pain at 7/10, 8/10, 9/10 and 5/10. The ___ physician reviewer explained that there is insufficient evidence to support a diagnosis of reflex sympathetic dystrophy or sustained pain relief from previous sympathetic blocks times 2. Therefore, the ___ physician consultant concluded that the requested left lumbar sympathetic block is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 19th day of June 2003.